teen and ten kilograms, while the control animals weighed thirty-six kilograms. The temperature of the animals operated upon was always one or two degrees lower than that of the normal animals. Besides the smallness of the animals, the form of the skull was peculiar. The fore part of the head was small, and the back part large. The horns did not develop. The bellies were always largely distended. The psychic condition of the animal was that peculiar to cretinism. An autopsy six months after operation showed general marasmus, absence of fat, no myxœdema, no accessory glands, and a calcareous deposit in the aorta. Of two goats operated upon, one showed the same retardation in growth and the same psychic condition. The autopsy showed no new glands. The other grew big and strong; and at the autopsy a large accessory thyroid gland was found in the aperture of the thorax.

The author refers to the changes which follow this operation as consisting in a feeble growth, associated with idiocy. The picture is very like that observed in the Alpine cretins. And as a conclusion, he claims that cretinism, myxœdema and cachexia strumipriva are diseases all dependent on a common ætiological factor—degeneration or absence of the thyroid gland.

He has examined thirteen cretins, and found, as Kocher did, that the thyroid gland might be entirely absent in such cases. He was unable to discover any thyroid in three of these thirteen.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

JAMES P. WARBASSE (Brooklyn).

HEAD AND NECK.

I. Endocranial Myelogenous Tumor of the Skull. By Prof. J. NICOLAYSEN (Christiania). A man of fifty years had for years suffered from periodic hæmicrania, either upon the right or left side and associated with vertigo, befogged vision and nausea. In March, 1892, he had had pain in his pharynx, under the right jaw and behind the right ear. These disappeared, and after that he

noticed a swelling in the right temple, which continued to grow. He entered the hospital July 21, when he was somewhat dull and had had persistent headache on the right side for the previous three weeks. In the right temporal region there was a tumor of the size of a child's fist, tensely elastic and immovable, but with distinct pulsation. It could be followed up from a hollow in the cranium, and it projected over the margins which were to be made out here and there; these latter were sensitive, especially at the lower borders. The tumor could not be influenced by pressure. No spasms nor paralyses; facial expression somewhat dull. It was removed by a flap-shaped incision running around it at about one centimetre distant from the margins. The temporal muscle was infiltrated and was removed with its fascia. The tumor was situated outside of the dura mater, which did not seem to be invaded, and only a few spots were scraped. One centimetre of the margins of the bone was removed all around. Hæmorrhage from the diploë was controlled by the thermo-cautery; that from the dura by iodoform gauze, the ends being left to hang out of the wound which was sutured. The neoplasm had produced a cavity in the brain of three and a half centimetres depth and four and a half breadth, which was filled with fluid albuminous substance of a yellowish, grayish-white color, and was without a distinct capsule. Microscopically the tumor consisted of closely-packed cells with small and easily-colored nuclei without inter-cellular substance. The wound healed by first intention, and the intra-cranial depression elevated itself spontaneously. He was well, looked more lively, did not complain of dulness, and was discharged as cured August 13.

The writer regards the tumor as a mylogenous sarcoma originating in the diploë and not from the periosteum, in which case there would have been a formation of osteophytes. The growth grew and absorbed the cranial wall, periosteum and temporal muscle and progressed outward. Internally it pushed the brain and its membranes aside, and in spite of this there were but few symptoms of pressure or cerebral symptoms beyond a little mental dulness. The pulsation probably proceeded from elevation of the cerebral mass. Before the

operation it could not with certainty be determined if the brain were infiltrated, but the indications for operation were decided. Unexpectedly the dura was found intact, firm and glistening. He calls attention to the immediate improvement in the patient's mental condition, for he answered questions better and recovered rapidly.—*Norsk Magazin for Lægevidenskaben*, pp. 1217–1219.

FRANK H. PRITCHARD (Norwalk, Ohio).

II. Fistula Colli Congenita. By Dr. SCHLANGE (Berlin). The author has presented two very interesting preparations of congenital branchial fistula. One was from the lateral side of the neck and had been extirpated in its entirety. It was lined with cylinder epithelium, resting upon lymphatic tissue, with numerous follicles. Outside of this was a layer of striped muscle fibres running in the direction of the fistula.

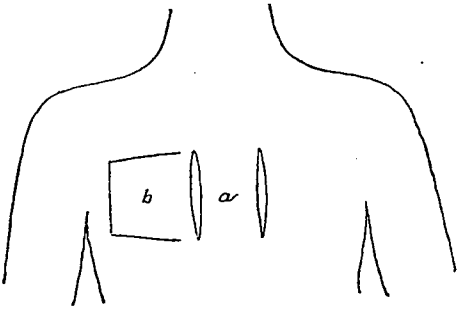
The second preparation was that of a fistula from the median line, which ended at the hyoid bone, which could be thoroughly removed only by the resection of a piece of the body of the bone one centimetre broad. The author regards this operation as necessary for a complete cure of median fistulæ, which instead of ending at the hyoid bone pass completely through it.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

III. A Method for Obtaining Double Skin Flaps for Plastic Operations. By Dr. CARL LAUENSTEIN (Hamburg). In the closing of defects in the cheeks it is necessary either to use flaps covered on one side with epidermis and on the other with mucous membrane or flaps covered on either side with epidermis. The first is almost impossible; the second can be accomplished by the method which Lauenstein has devised. He has reported a case in which he treated a defect of the cheek by a double-sided flap taken from the breast, and he recommends the method which he pursued for such cases in which material for the flap cannot be taken from the face or in which it is not desirable to further disfigure the face.

The patient on whom he operated had carried an epithelioma of the right cheek for sixteen years. He had been operated upon eight and five years before respectively. Lauenstein had done an excision three years before, and repaired the defect in the cheek by means of a flap, after Dieffenbach, from the upper part of the neck. Still the disease continued, and involved the cheek, the upper lip, the nose and lower eyelid. A final and more thorough operation was done. The defect in the nose was repaired by a flap from the left cheek. The defect in the right cheek was so great that food and drink escaped from the opening. To repair this defect with a double flap he proceeded as follows (see figures): The bridge *a* was dissected free, and the flap *b* cut loose on three sides, drawn under *a* and sutured by its end border to the free border of *a*. The defect left by the flap *b* was covered by Thiersch grafts. The pedicle *c* was then cut out in the direction of the neck. After the lateral incisions had been made cutting off the lateral circulation, the pedicle was dissected up from its underlying tissue, so that the circulation was supplied only through the ends. Then the lower attachments of the double flap were gradually cut through until the blood supply for the whole flap was through the upper attachment. This separation was done very gradually, and from time to time and before cutting elastic compression was made in order to observe whether the circulation from above was sufficient. At the end of thirty-nine days the double flap, which was about eight centimetres square, was found to be ready for transplantation, being entirely nourished by the pedicle, which in its narrowest place was three centimetres broad. Fourteen days after the transplantation into the cheek defect the pedicle was cut from the flap. Before severing it, repeated elastic compressions, the longest of which was five hours, had demonstrated that the transplanted flap was firmly healed in its new position.

The flap now closes the defect perfectly. The patient can smoke, blow and masticate perfectly. The result is not perfect from a cosmetic view because the flap is somewhat thicker than the surrounding tissue of the cheek. It could have been made thinner by taking

Fig 1.



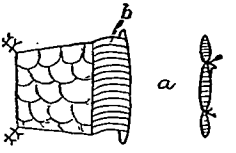


Fig 2.

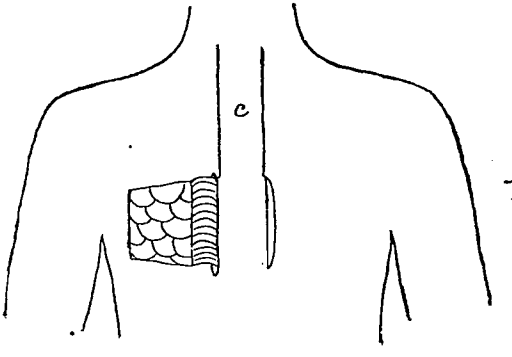


Fig 3.

less subcutaneous tissue.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

IV. Metastasis of Malignant Tumors of the Thyroid Gland. By VON EISELSBERG (Vienna). Metastases of malignant tumors of the thyroid occur most frequently in the lungs, and next in frequency in the bones. Von Eiselsberg calls especial attention to that variety of metastatic deposit in the bones in which the secondary growth presents the typical picture of thyroid adenoma, which has been described by Cohnheim, Wölfler, Cramer, Hinterstoisser and others. This tumor has been usually described as metastatic adenoma or malignant adenoma, and also as adeno-carcinoma.

He reports a striking case. A metastasis occurred in the parietal bone, which he removed, leaving a defect in the skull. The large goitre which the patient had caused no especial inconvenience. Four years after the operation recurrence was observed in the same place. Inasmuch as the patient was feeling perfectly well, he refused further operation. Examination of the extirpated nodule showed it to be adenoma with colloid degeneration.

He presented four similar cases. The first was a thyroid adenoma nodule of the skull vault; the second an isolated nodule of the same sort in the upper arm; the third a nodule on the base of the skull, and lastly multiple metastases in the lung, humerus and rib. In every case the primary tumor in the thyroid was so small that it had not been discovered during life. The secondary nodules were all of the type of thyroid adeno-carcinomata.

The peculiarities of these tumors are their localization in the bones, the solitary character of the metastasis, the slow growth, and lastly the frequently very small size of the primary tumor.

The metastases represent the normal thyroid glandular tissue in a very characteristic way. This is quite analogous to the bile-secreting, metastatic nodules with normal liver cells, reported by Perls and Bock in cases of primary carcinoma of the liver.

The clinical character of these metastases is very different from

that of the ordinary metastasis, for in the latter the surgeon sees a contra-indication to operation, whereas these should be operated upon, and by histological examination of the same the seat of the primary disease discovered and possibly extirpated.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

JAMES P. WARBASSE (Brooklyn).

CHEST AND ABDOMEN.

I. A Case of Subphrenic Pyothorax. By H. HOLSTI (Helsingfors, Finland). The writer relates the case of a man of thirty-two years who, formerly suffering from painful attacks, probably due to gall-stones, after he had had for twelve days severe pain in his chest, began to have chills, profuse perspiration, pain in his right side and to expectorate ochre-colored sputa. Upon exploratory puncture of a dull portion at the base of the right lung a serous fluid was obtained; lower down with a short needle also serous fluid, but with a longer needle an ill-smelling fluid of the same consistency as that which the patient expectorated. Resection of the ninth rib in the scapular line on the right side evacuated from the pleural cavity serous exudate. The diaphragm which arched upward toward the field of operation presented a small and fluctuating elevation, which upon exploratory puncture was found to contain badly-smelling pus. The wound was tamponaded with iodoform gauze and in a week, after adhesions had formed between the two portions of the pleura, the fluctuating spot in the diaphragm was incised and a cavity of the size of a plum was discovered filled with the same kind of pus. Later, in the anterior portion of the right side of the thorax quite a large encapsulated pyothorax formed, which was treated by the ordinary operation for empyema, after which the patient recovered. The writer thinks that besides the purulent focus operated upon there must have been others which communicated with the lungs and gave rise to the ochre-colored sputa. He reviews the various and varying methods of operation in subphrenic pyothorax, and recommends his method of procedure;